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No. 90-328

In the Supreme Court of the United States

OCTOBER TERM, 1990

BODIMETRIC HEALTH SERVICES, INC.,
BODIMETRIC HOME CARE, INC., AND
AMERICAN SERVICE BUREAU, INC., PETITIONERS,

v.

AETNA LIFE & CASUALTY AND
AETNA LIFE INSURANCE COMPANY, RESPONDENTS.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

REPLY BRIEF OF PETITIONERS

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REPLY BRIEF OF PETITIONERS

The Petitioners file this Reply Brief to respond to certain points raised by the Respondents and by the United States in their Briefs in Opposition to the granting of the Petition.

1. Petitioners must begin their response by addressing the presentation of statutory and regulatory provisions by Respondents and the United States which is likely to mislead this Court into an erroneous impression of the rights of providers to appeal intermediary claims determinations. At pages 3 and 4 of Respondents' and the United States' Briefs, it is stated that providers may request intermediary reconsideration of denied claims under 42 C.F.R. § 405.710(b) and, thereafter, that the provider has a right to review of the reconsidered decision by an administrative law judge under 42 U.S.C. § 1395ff(b)(2)(A) and may thereafter request review by the Appeals Council of HHS and, finally, if still dissatisfied, has a "right of appeal to a United States District Court. 42 U.S.C. § 1395ff(b)(2)(B); 42 C.F.R. § 405.730." Respondents' Brief 4.

Respondents and the United States imply that section 1395ff permits providers to appeal from any denial of claims. This grossly overstates a provider's access to the appeal process. The language of section 1395ff provides only for appeals by "individuals" (i.e., beneficiaries), not by providers. The most a provider can do under section 1395ff is to appear and represent the beneficiary; section 1395ff does not give a provider any appeal rights of its own.

The provider's appeal rights referred to by Respondents originate in 42 U.S.C. § 1395pp, "Limitation of liability

where claims are disallowed." Section 1395pp applies only to claims denied on the grounds that the services are not covered by Medicare because they are not medically necessary[1] or because they constitute custodial care,[2] or, for home health services, because the beneficiary is not confined to his home or does not need skilled nursing care on an intermittent basis.[3] 42 U.S.C. § 1395pp(c). Medicare will nonetheless pay a provider for such claims where the beneficiary or the provider, or both, can demonstrate that they did not know, or could not reasonably have been expected to know, that the service was not covered. A determination that a provider knew or could reasonably have been expected to know a service was not covered is the *only* determination for which a provider may seek reconsideration under 42 C.F.R. § 405.710(b).[4] Thereafter, a provider may seek review of this issue of the provider's knowledge concerning coverage by an administrative law judge, the HHS Appeals Council or Federal district court under the process provided for in section 1395ff, but then only if the beneficiary first refuses to exercise appeal rights. 42 U.S.C. § 1395pp(d).

Thus section 1395ff by itself is not a general remedy available to providers to appeal intermediary denials of individual beneficiary claims. Under section 1395ff, providers have no direct right to be heard; the most they have is a derivative remedy: the right to represent the beneficiary in an appeal. This derivative right and the appeal

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[1] 42 U.S.C. § 1395y(a)(1).

[2] 42 U.S.C. § 1395y(a)(9).

[3] 42 U.S.C. § 1395pp(g).

[4] *See* 42 C.F.R. § 405.704(c), which defines an initial determination with respect to a provider of services, for which reconsideration may be requested, as limited to this narrow issue.

rights under section 1395pp regarding knowledge of coverage are hardly the full panoply of appeal rights for providers with regard to intermediary denials of claims that is suggested by the presentation in the briefs submitted by Respondents and the United States.

2. Respondents and Intervenor United States assert that 42 U.S.C. § 1395ff provides an independent basis for the preclusion of the state law remedies which Petitioners seek from Respondents. Respondents' Brief 8, 9 and 15; United States' Brief 7. That assertion is without merit.

2a. As this Court recognized in *Bowen v. Michigan Academy of Family Physicians,* 476 U.S. 667, 674 (1986), "[s]ection 1395ff on its face is an explicit authorization of judicial review, not a bar." The decision in *United States v. Erika, Inc.,* 456 U.S. 201 (1982), concerning Court of Claims jurisdiction to review carrier fair hearing decisions under 42 U.S.C. § 1395u(b)(3)(C), at a time when section 1395ff provided neither administrative nor judicial remedies for the particular claims involved, does not convert section 1395ff from an affirmative grant of remedies to a bar. Rather, relying on the legislative history of that section concerning the types of claims that Congress specifically had withheld from the remedies of section 1395ff, the *Erika* Court simply concluded that the amount determinations sought by the supplier fell within the scope of the withheld remedies and thus there would be no jurisdiction in the Court of Claims to pursue those remedies. *Erika* does not say that remedies at State law for damages against an intermediary, as opposed to payment of benefits by the Medicare program, similarly are intended to be withheld from judicial review.

2b. As discussed above, on its face section 1395ff is a remedy for beneficiaries, not providers. Providers only

have a derivative remedy under section 1395ff in that they can not be precluded by the Secretary from representing beneficiaries in the pursuit of their remedies. To read that affirmative grant of remedies to beneficiaries concerning denials of their claims as being intended to bar providers' State law remedies against intermediaries for damages incurred from intermediary conduct outside of or contrary to the intermediary's contract requires a judicial rewriting of the plain language of section 1395ff.[5]

2c. In its arguments asserting section 1395ff as an independent bar, the United States would appear to limit the "method versus amount of payment" dichotomy in *Michigan Academy* to challenges to the Medicare regulations. United States' Brief 9-10. It then argues that a necessary element of Petitioners' cause of action is showing that the intermediary's amount determinations were incorrect and thus it is foreclosed by section 1395ff. *Id.* at 11.

As to that limited view of the scope of *Michigan Academy*, although that case did involve a statutory challenge to payment regulations, the *Michigan Academy* Court did not limit challenges cognizable outside of section 1395ff to challenges of regulations. It stated:

> We conclude, therefore, that those matters which Congress did *not* leave to be determined in a "fair

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[5] At page 8, note 10 of its Brief, the United States suggests that 42 U.S.C. §§ 405(h) and 1395ff would not preclude a common law tort remedy against intermediaries in contexts such as an assault committed by the intermediary's personnel upon a beneficiary who had come to the intermediary's office to discuss a claim. If, notwithstanding sections 405(h) and 1395ff, the beneficiary would have a State law remedy for damages suffered that the hands of an intermediary acting outside of or contrary to the scope of the intermediary contract in the course of claims administration, so would the provider. The fact that physical abuse was involved rather than economic abuse should not be determinative.

> hearing" conducted by the carrier—*including* [emphasis added] challenges to the validity of the Secretary's instructions and regulations—are not impliedly insulated from judicial review by 42 U.S.C. § 1395ff.

476 U.S. at 678.

It should be noted that, although framed as a statutory and constitutional attack on the Secretary's regulation providing that carriers could develop separate prevailing charges for specialists, and the carriers' implementation of that regulation, the gravamen of the attack in *Michigan Academy* was that the family practitioners were being paid less for their services to Medicare beneficiaries than were specialists providing the same services. Indeed, based upon that price differential, the lower court held that the regulation violated the Medicare Act. *Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan,* 728 F.2d 326, 332 (6th Cir. 1984).

Clearly, the challenge in *Michigan Academy* was bottomed on physician dissatisfaction with the amount determinations for their services. And just as clearly, that same challenge could have been *attempted* in the context of a beneficiary challenge to a carrier's amount determination under section 1395ff. On remand from this Court to determine the applicability of *Heckler v. Ringer,* 466 U.S. 602 (1984), the Secretary argued "that the claim of Michigan Academy is, in reality, a claim for benefits." *Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan,* 757 F.2d 91, 94 (6th Cir. 1985). Indeed, that same position, and the related position that statutory and constitutional challenges related to amount of benefits are precluded, was taken by the Secretary both in his briefs and at oral argument before this Court in

Michigan Academy.[6] Nonetheless, the *Michigan Academy* Court did *not* take the position that, because the statutory challenge arose from dissatisfaction with amount determinations, the challenge was mere "creative lawyering" that was foreclosed. Similarly, because Petitioners' damages under State law flow from the intermediary's wrongful conduct in the general context of amount determinations, they are not foreclosed under section 1395ff.

2d. Because section 1395ff is an affirmative grant of beneficiary remedies, its interpretation is at best a subsidiary issue with respect to the scope of the section 405(h) jurisdictional bar. The interpretation of 1395ff is discussed throughout the Petition and is fairly included in any discussion relating to the jurisdictional limitations of section 405(h). For that reason section 1395ff was not separately stated in Petitioners' statement of the question. Accordingly, the fact that the statement of the question did not specifically identify section 1395ff is not a basis for denying the writ.

3. The underlying premise in the briefs of both the Respondents and the United States is that the Petitioners are seeking payment of benefit amounts from Aetna in addition to consequential and punitive damages. Respondents' Brief 5, United States' Brief (I). Thus both the Respondents and the United States focus on the exclusive review mechanisms for amount of benefit determinations set forth in 42 U.S.C. § 1395ff as grounds for validating the decision of the Seventh Circuit below.

The reliance of Respondents and the United States on this premise ignores the Petitioner's acknowledgement, Pet. 9 n.7, that two of the categories of damages they seek

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[6] Brief for the Petitioners 24-25, 30-32; Reply Brief for the Petitioners 3, 8 n.8; Transcript of oral argument January 22, 1986, 8, 10.

which pertain to benefit amount may need to be severed from this action. Petitioners indicated that they sought these amounts *not* as benefits to be paid from Medicare Trust Fund but rather as damages which were the direct result of Aetna's wrongful scheme to deny claims wholesale, without regard to their merits, in order to improve its standing with the Secretary. Nonetheless, Petitioners recognize that if these two categories are construed by the Court to fall under the provisions of section 1395ff and 405(h), they should be severed so that the remainder of the Petitioners' State law claims for damages against the Respondents may be pursued. *Id.*

3b. Related to this faulty premise is the erroneous conclusion reached by the Seventh Circuit and expressed by both the Respondents and the United States: a ruling in favor of the Petitioners would require the trial court to review the merits of each of the 26,000 denied claims. Pet. App. 34a; Respondents' Brief 6; United States' Brief 11. This conclusion confuses the concepts of jurisdiction and methods of proof. Moreover, even if a trial court could be persuaded to permit such an approach to the evidentiary issues, this evidentiary problem is not the issue with which Congress was concerned. Rather, as the *Michigan Academy* Court explained, the congressional concern was with clogging the judicial system with a multiplicity of suits, each raising "quite minor" claims. 476 U.S. at 677.

The Petitioners contend that Respondents, to further their self-serving scheme, often declined to even consider the merits of individual claims in the first place, and it would not be necessary for a court to do so in order to determine Respondent's culpability. Without examining the merits of any particular claim, the factfinder could de-

termine that Respondents' conduct in certain areas[7] constituted such fraud or negligent misrepresentation as to prevent objective review of the merits of the claims initially. The issue then is not whether the decisions on the individual claims were *correct,* but whether they were the product of fraud or other tortious conduct.

As to matters of proof, it is critical to note that Petitioners have not yet had the right to discovery, which would produce further evidence of Respondents' grand plan and improper motives. Discovery could well reveal operating instructions to target the claims of Petitioner BHS, or to deny X percent or X dollars in claims without regard to merit. Such evidence, combined with Respondents' course of conduct and representations in meetings, the increase in the total number of claims reviewed and

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[7] These areas include:

- Aetna's use of a bonus or incentive system, rewarding its employees for the more claims they reviewed in a single day (Amended Complaint ¶ 25).
- Instructions to Aetna's employees to deny claims even if they knew denials would be reversed on appeal (Amended Complaint ¶ 28).
- Aetna's refusal to provide assistance relevant or information to Petitioner Bodimetric Health Services, Inc. (BHS) (Amended Complaint ¶ 46b).
- Aetna's misrepresentation at a series of meetings of the status of its review of BHS claims, which causes BHS to continue to elect to retain Aetna as its intermediary and not to change its method of providing service and documenting claims (Amended Complaint ¶¶ 34, 35).
- Aetna's continued misrepresentation that BHS' claims were being thoroughly reviewed, inducing BHS to continue to retain Aetna as its intermediary (Amended Complaint ¶¶ 25, 41).
- Aetna's "loss" of BHS claims and rejection of claims for insufficient postage, causing BHS to resubmit some claims as many as three to six times (Amended Complaint ¶¶ 43, 46i).

denied each day, Respondents' "cost to savings" ratio of dollars denied to dollars spent on review, and statistics showing gross denial rates of Respondent which increased dramatically following its performance evaluation and which reached 100% at some BHS offices (Amended Complaint ¶ 46a) can be established and documented without reviewing the merits of each claim.

4. Respondents contend that the Petitioners failed to expressly refute or criticize the Seventh Circuit's discussion of section 405(h) with respect to diversity jurisdiction. Respondents' Brief 10. The contention is irrelevant for purposes of determining whether the Petition should be granted.

The Petition focuses on the primary and larger question raised by the third sentence of section 405(h): whether Petitioners' suit against Respondents constitutes a "claim arising under" the Medicare statute. Petitioners contend that their suit is *not* such a claim, and therefore section 405(h) does not apply. Under this reading, the alternative arguments of whether, if Petitioners' suit is such a claim, section 405(h) precludes diversity jurisdiction or whether a fiscal intermediary is "an officer or employee" of the United States are never reached.

If the Petition is granted with respect to the scope of section 405(h), then Petitioners will of course brief these alternative arguments based on the language of section 405(h), for under Supreme Court Rule 14.1(a), the statement of the question is "deemed to comprise every subsidiary question fairly included therein." But the absence of a discussion of these secondary, alternative arguments in the Petition provides no reason for denying the Petition.

5. Finally, the United States asks this Court to deny the Writ based upon its arguments as to the merits of the controversy. The United States does not suggest that this issue is not important or is not appropriate for the Court's attention. If these complex issues are to be resolved, they should be resolved only after a full briefing and argument on the merits, not by denying the Petition.

CONCLUSION

For the foregoing reasons, the Writ should be granted.[8]

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[8] The listing required by Rule 29.1 was submitted in the Petition for Writ of Certiorari filed on August 20, 1990.